MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10060 Reg. Dist. No. 10054

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY IN 1b 75 Jears ?
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 122 Penna. Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
d. STREET ADDRESS 122 Penna Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MARY Middle B. Last ARBAUGH

4. DATE OF DEATH Month SEPT. Day 23 Year 1961

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH June 18, 1880
9. AGE (In years last birthday) 81 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Annealer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Yellowneck
14. MOTHER'S MAIDEN NAME Barbara Michael

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. ?
INFORMANT Mrs Elizabeth Rose Address 108 East Green St. Westminster

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Renal disease — INTERVAL BETWEEN ONSET AND DEATH Several yrs
DUE TO (b) Hypertension & Arteriosclerosis General — Several yrs
DUE TO (c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 7, 1959, to Sept 23, 1961, that I last saw the deceased alive on Sept 23, 1961, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN Wylene Speicher ADDRESS (Street, city or town, state) Westminster Md DATE SIGNED 9/25/61
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/26/61
22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery
22d. LOCATION (City, town, or county) (State) Westminster, Md.

23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers Jr. ADDRESS Westminster Md.
24a. REC'D BY REGISTRAR DATE SEP 27 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10061

CERTIFICATE OF DEATH

10055

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville,
   c. LENGTH OF STAY IN 1b: 14yrs.10mos.3dys.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Balto. City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 4 N. Front Street
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Frederick — Middle: George — Last: Bauman

4. **DATE OF DEATH**: Month: September — Day: 24, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 25, 1895

9. AGE (In years last birthday): 65 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Bauman

14. MOTHER'S MAIDEN NAME: Catherine Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes 6-2-18 to 12-23-18

16. SOCIAL SECURITY NO.: 579-16-8057

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: days

420.0

DUE TO (b): Coronary occlusion — days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Arteriosclerotic heart disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychosis with chronic alcoholism, delirium tremens. Moderately advanced bilateral pulmonary tuberculosis, activity questionable

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-21-1946 to 9-24-, 19 61 that (I) (we) last saw the deceased alive on 9-24- 19 61., and that death occured at 2:30 p.m., from the causes and on the date stated above.

22a. SIGNATURE: J. Radzykewycz M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9-24-61

22c. PHYSICIAN'S NAME (Type): Julian Radzykewycz, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-26-61

23c. NAME OF CEMETERY OR CREMATORY: New Cathedral

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Wright — ADDRESS: Sykesville, Md

25a. REC'D BY REGISTRAR DATE: SEP 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10062 10056

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Union Mills
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Meadow View Convlesent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pa.
b. COUNTY: Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Oxford
d. STREET ADDRESS: 4 Lincoln Way West
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY Middle ELIZABETH Last BITTINGER

4. DATE OF DEATH: Month SEPT. Day 8 Year 1961

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 18, 1871
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Adams Co. Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel D. Deordorff
14. MOTHER'S MAIDEN NAME: Anna Wentz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 178 16 0544
17. INFORMANT: Clarence Bittinger Address: New Oxford, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1959 to Sept 8 1961, that (I) (we) last saw the deceased alive on Sept 7 1961, and that death occurred at 4:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James T. Marsh M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/8/61
22c. PHYSICIAN'S NAME (Type): JAMES T MARSH
22d. ADDRESS: Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/10/1961
23c. NAME OF CEMETERY OR CREMATORY: Green Mount Cemetery
23d. LOCATION (City, town, or county) (State): Arentsville Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. ADDRESS: Westminster, Md.
25a. REC'D BY REGISTRAR DATE: SEP 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10063 10057

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 7 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Montgomery
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
   d. STREET ADDRESS: 102 Normandy Drive 1522-2
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Susie; Middle: Lee; Last: Bocrie

4. DATE OF DEATH: Month: September; Day: 5; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 8, 1876

9. AGE (In years last birthday): 84 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Milligan

14. MOTHER'S MAIDEN NAME: Sarah Lightfoot

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
420.0
DUE TO
(b): Terminal bronchopneumonia — Days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. with cerebral arteriosclerosis and paranoid reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-28-, 1961 to 9-5-, 1961, that (I) (we) last saw the deceased alive on 9-5-1961, and that death occured at 10:20 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 9-5-61

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.
22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/7/61
23c. NAME OF CEMETERY OR CREMATORY: Forest Lawn Cemetery
23d. LOCATION (City, town or county) (State): Norfolk, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Reed Funeral Home
ADDRESS 4812 GA. AVE. WASH. D.C.
25a. REC'D BY REGISTRAR DATE: SEP 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10064

CERTIFICATE OF DEATH

10058

M

015

I

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.4mos.4dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
3 VOL-4
d. STREET ADDRESS: 212 W. Monument Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie — Middle: Hartman — Last: Brush

4. DATE OF DEATH: Month: September — Day: 5 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: September 18, 1873

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Augustusa Hartman

14. MOTHER'S MAIDEN NAME: Catherine Shertzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — Interval between onset and death: Years
420.0
DUE TO (b): Generalized ~~hhh~~ arteriosclerosis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-1-, 19 59 to 9-5-, 1961, that (I) (we) last saw the deceased alive on 9-5- 1961, and that death occured at 10:25 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9-5-61

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/8/61

23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge

23d. LOCATION (City, town or county) (State): Pikesville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wm. T. Tickner + Sons, North + Pa. Ave - Baltimore, Md.

25a. REC'D BY REGISTRAR — DATE: SEP 8 '61

25b. REGISTRAR'S SIGNATURE: Charles S. Knauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10065

Item 23a, Film 6295 9/19/61 1wk

10059

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 135 S. Morley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James; Middle: E.; Last: Bullock

4. DATE OF DEATH: Month: September; Day: 8; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-22-1925

9. AGE (In years last birthday): 36 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Shipyard

11. BIRTHPLACE (State or foreign country): Norline, N. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis Bullock

14. MOTHER'S MAIDEN NAME: Ruth Russell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 240-34-9012

17. INFORMANT: Address: James E. Bullock - Patient

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Far advanced pulm. tbc. right with a cavity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Cancer of the lung
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-16-61, 19__, to 9-8-61, 19__, that (I) (we) last saw the deceased alive on 9-8-, 1961, and that death occurred at 12:30 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M. D.

22d. ADDRESS: Henryton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried

23b. DATE THEREOF: 9/13/61

23c. NAME OF CEMETERY OR CREMATORY: Arlington M.P.

23d. LOCATION (City, town, or county) (State): Arlington Md

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph W Green ADDRESS 2537 W Lafayette ave

25a. REC'D BY REGISTRAR DATE SEP 13 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any d... is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the fune... director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10066 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10060

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Mt. Airy
c. LENGTH OF STAY IN 1b: 10 Mo.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Boteler Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy
d. STREET ADDRESS: Boteler Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELSIE Middle L. Last BYERS

4. DATE OF DEATH: Month September Day 3, Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 25, 1876 ~~1877~~

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: domestic

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Jesse N. Butler

14. MOTHER'S MAIDEN NAME: Martha J. Farver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: ------

17. INFORMANT Address: Mr. Keith Byers, Same as # 2

MEDICAL CERTIFICATION

18. ~~CAUSE OF DEATH~~ [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): A.S.C.V. disease — INTERVAL BETWEEN ONSET AND DEATH: Yrs —
DUE TO (b): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ___

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh M.D.

EXAMINER'S NAME (Type): JAMES T. MARSH

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county) (State)

DATE SIGNED: 9/3/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-6-1961

22c. NAME OF CEMETERY OR CREMATORY: Pine Grove Cemetery

22d. LOCATION (City, town, or country): Mt. Airy, Maryland

23. FUNERAL DIRECTOR ADDRESS: C. M. Waltz, Winfield, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 6 '61

24b. REGISTRAR'S SIGNATURE: C. Thos. S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10067 10061

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: —

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville

c. LENGTH OF STAY IN 1b: 2y. 8m. 19d.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Springfield State Hospital

d. STREET ADDRESS: 610 N. Collington Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: A. Lost: Chiriconi

4. DATE OF DEATH: Month: 9 Day: 19 Year: 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/17/1886

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Italy - Florence

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Caesar Martinelli

14. MOTHER'S MAIDEN NAME: Justin ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-18-8477

17. INFORMANT: Springfield Hospital records — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

420.1

DUE TO (b): Cardiac insufficiency — years

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

DUE TO (c): Possible coronary

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS associated with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from December 30 '58 to 9/19 1961, that ☐ (we) last saw the deceased alive on 9/19 1961, and that death occurred at 9 A. M. from the causes and on the date stated above.

22a. SIGNATURE: N. Naci N Buyukunsal M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/23/61

23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.

23d. LOCATION (City, town, or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Schimunek Funeral Home, Inc. 2601 E. Madison St.

25a. REC'D BY REGISTRAR DATE: SEP 21 '61

25b. REGISTRAR'S SIGNATURE: Clarence L. Krause

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10068

10062

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 281 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Church Hill, Maryland
d. STREET ADDRESS: 17X-J
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara; Middle: ; Last: Conyer

4. DATE OF DEATH: Month: September; Day: 6; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-16-1890

9. AGE (In years lost birthday): 71 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT Address: Queen Anne's County Welfare Bd. - Centreville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Far adv. bilateral pulm. tbc. mostly right with cavitation.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II af item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this haspitol) attended the deceased from Nov. 29, 1960, to Sept. 6, 1961, that (I) (we) last saw the deceased olive on Sept. 6, 1961, and that death occurred at ____ M, from the couses and on the date stated above.

22a. SIGNATURE: Edgar M. Maculans M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: Sept. 6, 1961

22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M. D.

22d. ADDRESS: Henryton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: SEPT. 9
23c. NAME OF CEMETERY OR CREMATORY: CHURCH HILL COLORED
23d. LOCATION (City, town, or county): CHURCH HILL (State): MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Edgar L Sam
ADDRESS: Church Hill Md

25a. RECD BY REGISTRAR DATE: SEP 11 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kinnard

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10069 10063

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gamber
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gamber
d. STREET ADDRESS Finksburg P.O.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First FRANK Middle D. Last CRESWELL
4. DATE OF DEATH Month Sept. Day 28 Year 1961

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 1, 1903
9. AGE (In years last birthday) 58 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Good year Tire Worker
10b. KIND OF BUSINESS OR INDUSTRY Rubber Tire Co
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William S. Creswell
14. MOTHER'S MAIDEN NAME Elizabeth Streaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 213-01-9262
17. INFORMANT Address Mrs Louise Creswell - above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis, rheumatic Heart — INTERVAL BETWEEN ONSET AND DEATH 1956
DUE TO (b) Disease - Cardiac failure, — TO 1961
DUE TO (c) —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956 19 to 1961 19, that (I) (we) last saw the deceased alive on 28 Sept 1961, and that death occurred at 4:30 PM, from the causes and on the date stated above.

22a. SIGNATURE Howard E. Hall M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 29 Sept 61
22c. PHYSICIAN'S NAME (Type) HOWARD E. HALL
22d. ADDRESS Hampstead Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Oct. 2, 1961
23c. NAME OF CEMETERY OR ~~CREMATORY~~ Evergreen Memorial
23d. LOCATION (City, town, or county) (State) Finksburg Carroll Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE Luther H. Haight ADDRESS Sykesville, Md.
25a. REGISTRAR DATE OCT 2 61
25b. REGISTRAR'S SIGNATURE Arthur L. Frank

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10070 10064

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster
c. LENGTH OF STAY IN 1b: 25 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RFD #6

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Westminster
d. STREET ADDRESS: R.F.D. #6
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRY Middle AULDON Last DOBSON
4. DATE OF DEATH: Month SEPT. Day 17 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 31 1902
9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor of Assessments
10b. KIND OF BUSINESS OR INDUSTRY: Carroll Co. Md.
11. BIRTHPLACE (State or foreign country): Talbot Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Harry Dobson
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-14-2019
17. INFORMANT: Mrs. Thelma W. Dobson, Address: Same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Patient delirious (Amblyphia) — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Myocardiac (Ac)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 356.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 19 61 to Sept 17 19 61, that (I) (we) last saw the deceased alive on Sept 15 61, and that death occurred at 7:30 A, from the causes and on the date stated above.

22a. SIGNATURE: Wm C Jennette M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-18-61
22c. PHYSICIAN'S NAME (Type): Wm Carl Jennette M.D.
22d. ADDRESS: Westminster Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/20/61
23c. NAME OF CEMETERY OR CREMATORY: Deer Park Meth. Cemetery
23d. LOCATION (City, town, or county) (State): Smallwood Carroll Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J. E. Myers, Jr. Westminster, Md.
25a. REC'D BY REGISTRAR DATE: SEP 21 '61
25b. REGISTRAR'S SIGNATURE: Catherine L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10071 Items 23c & d, Film 0295 9/18/61 iwk 10065

M

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1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster
c. LENGTH OF STAY IN 1b: 10 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Westminster RD#4

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cranberry Road

d. STREET ADDRESS: Cranberry Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GRACE Middle VIOLA Last DULL

4. DATE OF DEATH: Month SEPT. Day 9 Year 1961

5. SEX: f Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 20, 1900

9. AGE (In years last birthday): 61 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): shoe-factory, hand operator

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carroll Co., Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Barnes

14. MOTHER'S MAIDEN NAME: Elizabeth Hoffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ___ (If yes, give war or dates of service) ___

16. SOCIAL SECURITY NO.: 216-03-9110

17. INFORMANT: Arthur E. L. Dull, Same address
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Vascular Renal disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
DUE TO
(b): Arterio Sclerosis & Hypertension — 5-6 yrs
DUE TO
(c): Stroke Rt Side — 1959

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 7, 1961 to Sept 8, 1961, that (I) (we) last saw the deceased alive on Sept 8 1961, and that death occurred at 4.7 M, from the causes and on the date stated above.

22a. SIGNATURE: Wglenn Speicher M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/11/61

22c. PHYSICIAN'S NAME (Type): W. GLENN SPEICHER

22d. ADDRESS: Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/13/61

23c. NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery

23d. LOCATION (City, town, or county) (State): Sandymount Carroll Co Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. S. Myers Jr.

ADDRESS: Westminster, Md.

25a. REC'D BY REGISTRAR DATE: SEP 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur E. Flowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10072

10066

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown
d. STREET ADDRESS: Middle Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ada; Middle: Reindollar; Last: Englar

4. DATE OF DEATH: Month: September; Day: 21; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 14, 1889

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months; Days; Hours; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical work

10b. KIND OF BUSINESS OR INDUSTRY: Newspaper

11. BIRTHPLACE (State or foreign country): Taneytown, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Preston B. Englar

14. MOTHER'S MAIDEN NAME: Margaret L. Reindollar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Miss Beulah Englar, Taneytown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Adenocarcinoma of the Uterus — INTERVAL BETWEEN ONSET AND DEATH: 14 mo.

174 X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Coronary Heart Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. / p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Aug 1955, to Sept 27 1961, that (I) (we) last saw the deceased alive on Sept 9 1961, and that death occurred at 12:58 PM, from the causes and on the date stated above.

22a. SIGNATURE: E. Ambler Thompson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/22/61

22c. PHYSICIAN'S NAME (Type): E. AMBLER Thompson

22d. ADDRESS: 49 Frederick St.-Taneytown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 23, 1961

23c. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery

23d. LOCATION (City, town, or county) (State): Taneytown, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John A. Skiles

ADDRESS: C.O. Fuss & Son — Taneytown, Maryland

25a. REC'D BY REGISTRAR DATE: SEP 25 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10073

CERTIFICATE OF DEATH

Items 8 & 9 Film G297 10/2/61 mh

10067

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pa... may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely ... in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
e. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 16 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 162 Pennsylvania Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Annie — Middle: Louise — Last: GLADFELTER

4. DATE OF DEATH: Month: 9 — Day: 23 — Year: 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/14/72

9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ephraim Ernst

14. MOTHER'S MAIDEN NAME: Manda Marks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Springfield State Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

420.0

DUE TO (b): Generalized arteriosclosis, marked. — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS assoc. with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/5/60, 19..., to 9/23/61, 19..., that (I) (we) last saw the deceased alive on 9/23/61 19..., and that death occured at 2 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/23/61

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-25-61

23c. NAME OF CEMETERY OR CREMATORY: Greenmount

23d. LOCATION (City, town or county) (State): York, Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: Luther A. Wright — ADDRESS: Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: SEP 25 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10074 [redacted] 10069

M

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 2yr. 3mos. 25da.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: Route #4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

015 21X-2

3. NAME OF DECEASED (Type or print): First: Missouri — Middle: Mae — Last: GRIFFITH

4. DATE OF DEATH: Month: September — Day: 29 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-30-83
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elias Griffith
14. MOTHER'S MAIDEN NAME: Sallie McMullen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
491X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS associated with senile brain disease, with psychotic reaction.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 6-4 1959, to 9-29 1961 that ☒ (we) last saw the deceased alive on 9-28 1961, and that death occurred at 2:10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Ilse Kamm M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 9-29-61
22c. PHYSICIAN'S NAME (Type): Ilse Kamm, M. D.
22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10-1-61
23c. NAME OF CEMETERY OR CREMATORY: Salem
23d. LOCATION (City, town, or county) (State): Rural Hagerstown Washington Md

24. FUNERAL DIRECTOR'S SIGNATURE: Howard F. Stone — ADDRESS: Williamsport Md
25a. REC'D BY REGISTRAR DATE: OCT 3 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Item 20 Film 295 9-22-61 ans

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10068

FOR STATE HEALTH DEPT. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Balto. County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville — c. LENGTH OF STAY IN 1b: 4 mo. 13 dys.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital	d. STREET ADDRESS: 8559 Water Oak Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Julia	May	Halberstadt	September	14	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		May 24, 1882	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Daniel Tyler	Hanna O'Neil

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No -	-	Springfield Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Asphyxia due to occlusion of larynx and bronchi with food. — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO (b) Arteriosclerotic heart disease. — Years

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 921.7

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with senile brain disease.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
	Aspirated food

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
-	- 19		S.S. H.	Sykesville	Carroll	Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE James T. Marsh M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED

EXAMINER'S NAME (Type) James T. Marsh, M.D. — Address (Street, city, town, or county)

9-14-61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	9-18-61	Holy Cross Cemetery	Brooklyn, A.A.Co. Md.

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
C. Vernon Lemmon 4611 Park Hgts. Balto.	SEP 18 '61	Arthur S. Krause

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any d... is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the fun... Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10076

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10070

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Westminster RT#1
c. LENGTH OF STAY IN 1b: 10 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Littlestown Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural, Westminster RT#1
d. STREET ADDRESS: Littlestown Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CECIL — Middle: GRANT — Last: HARRIS

4. DATE OF DEATH: Month: Sept — Day: 11 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 14, 1934

9a. AGE (In years last birthday): 27 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator, Shoe factory

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Stuart Va.

12. CITIZEN OF WHAT COUNTRY?: U-S-A.

13. FATHER'S NAME: Ulysses Grant Harris

14. MOTHER'S MAIDEN NAME: Frances ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give wer or dates of service): —

16. SOCIAL SECURITY NO.: 218-32-0495

17. INFORMANT: Mildred H. Harris, Address: Same address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound of head — INTERVAL BETWEEN ONSET AND DEATH:

976X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Part I or Part II of item 18.): Self inflicted

20c. TIME OF INJURY Hour: 5:15 p.m. — Month, Day, Year: 9/11/61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Westminster (County): Carroll (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T Marsh M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JAMES T MARSH

Address (Street, city, town, or county): Westminster Md

DATE SIGNED: 9/13/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/14/61

22c. NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery

22d. LOCATION (City, town, or country) (State): Rural Westminster, Md.

23. FUNERAL DIRECTOR — ADDRESS: J. E. Myers Jr. Westminster, Md

24a. REC'D BY REGISTRAR DATE: SEP 15 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10077 10071

1. PLACE OF DEATH a. COUNTY: Carroll Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Union Bridge
c. LENGTH OF STAY IN 1b: 11 Months
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Brookfield Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Finksburg RD
d. STREET ADDRESS: Near Eastview
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTIA Middle MAY Last Herbert
4. DATE OF DEATH: Month 9 Day 24 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 31, 1875
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home-wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carroll Co.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Hess
14. MOTHER'S MAIDEN NAME: Belinda Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Address: Mrs John H. Bollinger, Finksburg Md RD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): Generalized Arteriosclerosis — Years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Osteoporosis; Compression fractures T12 + L2 vertebrae.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 18, 1961 to Sept 24, 1961, that (I) (we) last saw the deceased alive on Sept 23 1961, and that death occurred at 12:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: J. H. Caricofe M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9/24/61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Union Bridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/26/61
23c. NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery
23d. LOCATION (City, town, or county) (State): Smallwood, Carroll Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. ADDRESS: Westminster, Md.
25a. REC'D BY REGISTRAR DATE SEP 27 '61
25b. REGISTRAR'S SIGNATURE: Emilius S. Haines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10078 10072

1 M I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 mo. 12 dys
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Unknown~~ Ellicott City
d. STREET ADDRESS: - 13X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Lillie	May	Kemp		September	20	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White		September 12, 1889	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
~~Unknown~~ None	- None	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
~~Unknown~~ Ezra Kemp	~~Unknown~~ Florence Ramsburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	-	None		Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Old and new myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Months & Days

420-1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary arteriosclerosis — Years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-8- 19 61 to 9-20- 1961, that (I) (we) last saw the deceased alive on 9-20- 19 61, and that death occured at 10:15 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 9-20-61

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.
22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	9-22-61	St. Johns	Ellicott City, Md

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
F.C. Higinbothom,	Ellicott City, Md	SEP 25 '61	Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10073

10073

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 34 Days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Henryton State Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke
d. STREET ADDRESS: RFD 1 Box 122
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Julia; Middle: F.; Last: Kersey

4. **DATE OF DEATH**: Month: September; Day: 19; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-13-1882

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Appomattox Co. , Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: L. James Handy

14. MOTHER'S MAIDEN NAME: Louise Conquest

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-03-2260

17. **INFORMANT** Address: Julia F. Kersey- Same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Insufficiency of Aorta — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
002X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Sclerosis, old age
DUE TO
(c): Min. pul. tbc., pleurisy, atlectasis rt. mid.lobe

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 16 1961 to Sept. 19 1961, that (I) (we) last saw the deceased alive on Sept. 19 1961, and that death occurred at 4:30AM, from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐
22b. DATE SIGNED: 9-19-61

22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M.D.

22d. ADDRESS: Henryton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-22-61
23c. NAME OF CEMETERY OR CREMATORY: Linsley Chapel
23d. LOCATION (City, town, or county) (State): Pocomoke, md.

24. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton
ADDRESS: New Church, Va.

25a. REC'D BY REGISTRAR DATE: SEP 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10080

CERTIFICATE OF DEATH

Reg. Dist. No. 10074

1. PLACE OF DEATH
a. COUNTY Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
c. LENGTH OF STAY IN 1b 15 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION County Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster
d. STREET ADDRESS 7
e. IS RESIDENCE ON A FARM? YES X NO

3. NAME OF DECEASED (Type or print) First CLEVELAND Middle B Last LEESE

4. DATE OF DEATH Month Sept Day 5 Year 1961

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐
8. DATE OF BIRTH May 22 1886
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jeremiah Leese
14. MOTHER'S MAIDEN NAME Annie Bixler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NO
INFORMANT Address Mrs Ross Weaver - Manchester Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Progressive
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cardiovascular Disease — Chronic
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hernia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-25-61, 19__, to 9-5-61, 19__, that I last saw the deceased alive on 9-3-61, 19__, and that death occurred at 8 P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE W. C. Stone M.D. Westminster Md

PHYSICIAN'S NAME (Type) W. C. Stone

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-8-1961
22c. NAME OF CEMETERY OR CREMATORY John L Miller cemetery
22d. LOCATION (City, town, or county) (State) Carroll Co Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Tipton-Eline, Hampstead Md

24a. REC'D BY REGISTRAR DATE SEP 8 '61
24b. REGISTRAR'S SIGNATURE Arthur E. Krouse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10081

10075

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 10m. 4d.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 24
3V01-4
d. STREET ADDRESS: 3030 Hudson Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Czeslawa ~~Cecilia~~ Middle: Helen Last: Lenczewska (Lentz)

4. DATE OF DEATH: Month: September Day: 1 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 2, 1885

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? Poland ✓

13. FATHER'S NAME: George Chrobocinski

14. MOTHER'S MAIDEN NAME: Caroline Gajewska

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: 216-10-8208

17. INFORMANT: Springfield State Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	IMMED.
DUE TO (b)	CORONARY INSUFFICIENCY	1 MO.
DUE TO (c)	CARDIAC FAILURE	6 MO.

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

C.B.S. associated with cerebral arteriosclerosis, without qualifying phrase. ELEVATION - CAUSE UNKNOWN.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-26 1961, to 9-1 1961, that (I) (we) last saw the deceased alive on 9-1 1961, and that death occurred at 11:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R.V. Houck Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9-2-61

22c. PHYSICIAN'S NAME (Type): R.V. Houck, Jr., M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/5/61
23c. NAME OF CEMETERY OR CREMATORY: Holy Rosary
23d. LOCATION (City or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: M.F.SADOWSKI & SONS, 1808 EASTERN AVENUE

25a. REC'D BY REGISTRAR DATE: SEP 5 '61

25b. REGISTRAR'S SIGNATURE: Esther L. Krantz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10082

10076

1. PLACE OF DEATH a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead RD#1
c. LENGTH OF STAY IN 1b: 8 yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: New Manchester

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead RD#1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First MOLLIE Middle BELLE Last MILLER

4. DATE OF DEATH: Month Sept Day 6 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 19 1880
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home - wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Carroll Co. Md. U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thmas B. Gilbert
14. MOTHER'S MAIDEN NAME: Sarah Arthur

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Address: Mrs. Geo. W. Vaughn, Same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Bladder — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs
181.0
DUE TO (b):
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Cardio Vascular Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1954 to Sept 6, 1961, that (I) (we) last saw the deceased alive on Sept 4 1961, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W H Foard M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): W H FOARD MD.
22d. ADDRESS: Manchester, Md 9/7/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/9/61
23c. NAME OF CEMETERY OR CREMATORY: Bennet Church Cemetery
23d. LOCATION (City, town, or county) (State): Pyrmont Carroll Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. Westminster, Md.
ADDRESS
25a. REC'D BY REGISTRAR DATE: SEP 11 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10083 Reg. Dist. No. 1007

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster Md
c. LENGTH OF STAY IN 1b 5 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jordan's Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Penna. b. COUNTY Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 213 So. Queen St. 75x-3
d. STREET ADDRESS Littlestown, Pa.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First EDNA Middle JOSEPHINE Last PENN

4. DATE OF DEATH Month Sept. Day 13 Year 1961

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH May 23, 1872
9. AGE (In years last birthday) 89 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Abraham Willett
14. MOTHER'S MAIDEN NAME Elizabeth Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Harry F. Feser, Bond St. Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Fractured hip —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr 3, 1961, to Sept 13, 1961, that I last saw the deceased alive on Sept 12, 1961, and that death occurred at 2:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE James T Marsh M.D. ADDRESS (Street, city or town, state) DATE SIGNED 9/13/61
PHYSICIAN'S NAME (Type) JAMES T MARSH Westminster Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/15/61
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery
22d. LOCATION (City, town, or county) (State) Silver Run Md.

23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers Jr. ADDRESS Westminster, Md.
24a. REC'D BY REGISTRAR DATE SEP 15 '61
24b. REGISTRAR'S SIGNATURE Alma L Rinehart

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10084 10078

M

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg
c. LENGTH OF STAY IN 1b 3½ Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brookfield Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodsboro
d. STREET ADDRESS 10X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ALICE Middle VIRGINIA Last RICE

4. DATE OF DEATH Month Sept. Day 23 Year 1961

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Nov. 25, 1873
9. AGE (In years last birthday) 87 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

I

13. FATHER'S NAME Martin Eyler
14. MOTHER'S MAIDEN NAME Catherine Eyler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Address Mrs. Mary R. Beall, Woodsboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/7/61 19___ to 9/23/61 19___, that (I) (we) last saw the deceased alive on 9/19/61 19___, and that death occurred at 3:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE J. H. Caricofe M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 9/23/61
22c. PHYSICIAN'S NAME (Type) J. H. CARICOFE
22d. ADDRESS Union Bridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9/26/1961
23c. NAME OF CEMETERY OR CREMATORY Rocky Hill Cemetery
23d. LOCATION (City, town, or county) (State) Mt. Woodsboro, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. C. Barton, Walkersville, Md.
25a. REC'D BY REGISTRAR DATE SEP 26 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10085

CERTIFICATE OF DEATH

10079

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): rural Westminster
   c. LENGTH OF STAY IN 1b: 38 years
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If institution: residence before admission)
   a. STATE: Maryland
   b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural Westminster R. D. #7
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Richard — Middle: Hardesty — Last: Richardson

4. **DATE OF DEATH**: Month: September — Day: 27 — Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 9, 1894

9. AGE (In years last birthday): 67 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired road builder & farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland Belair, Harford County

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Richardson

14. MOTHER'S MAIDEN NAME: Elizabeth Courtright Hardesty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes
    (If yes give war or dates of service): World War I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. R. H. Richardson — Address: same address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive myocardial infarction.
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): A.S.C.V.D.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Sudden / About one hr. and 45 mi. / ? yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/23/1940, 19..... to 9/27/61, 19....., that (I) (~~we~~) last saw the deceased alive on 9/27/61 19....., and that death occured 2.45A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edwin B Jarrett M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Edwin B. Jarrett, M.D.

22d. ADDRESS: 11 East Chase St., City-2.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 9/29/61

23c. NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery

23d. LOCATION (City, town or county) (State): rural Westminster Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J. R. Myers Jr., Westminster, Md.

25a. REC'D BY REGISTRAR DATE: SEP 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10086 10080

1. PLACE OF DEATH
a. COUNTY: Carroll Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester Md
c. LENGTH OF STAY IN 1b: 1yr. 1mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Longview Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 12 Ridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ADA Middle ELIZABETH Last ROBB

4. DATE OF DEATH: Month Sept. Day 13 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 9, 1875
9. AGE (Last birthday) 86 yrs.
IF UNDER 1 YEAR Months / IF UNDER 24 HRS. Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house-wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Somerset Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Watson
14. MOTHER'S MAIDEN NAME: Sarah R. Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Miss Addie Belle Robb
Address: 12 RIDGE ROAD, Westminster Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs
4221
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6/9 1961, to Sept 13 1961, that (I) (we) last saw the deceased alive on 9-12 1961, and that death occurred 6:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: W H Foard M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): W H Foard M.D
22d. ADDRESS: Manchester, Md 9-13-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/15/61
23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
23d. LOCATION (City, town, or county) (State): Baltimore Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr.
ADDRESS: Westminster, Md.
25a. REC'D BY REGISTRAR DATE: SEP 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10087

CERTIFICATE OF DEATH

10081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 24yrs.1mo.16days

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Balto.City ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   3V01-4
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital
   d. STREET ADDRESS: 3402 Clifton Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

515

3. **NAME OF DECEASED** (Type or print): First: Robert — Middle: F. — Last: Rynehart

4. **DATE OF DEATH**: Month: September — Day: 15, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 30, 1887

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Rynehart

14. MOTHER'S MAIDEN NAME: Susan Brice

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give wer or dates of service): -

16. SOCIAL SECURITY NO.: -

17. **INFORMANT** Address: Springfield Hospital Records.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

521X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Lung abscess — Weeks
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Involutional psychosis, paranoid type.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 29, 19 37 to September 15 1961, that (I) (we) last saw the deceased alive on September 15, 19 61, and that death occured at 9:15 AM. from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/15/61

22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.

22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/16/61

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park

23d. LOCATION (City, town or county) (State): Balto., Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Tickner Sons — ADDRESS: Baltimore 17, Md.

25e. REC'D BY REGISTRAR DATE SEP 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Items 20&21 Film 295 0-15 61 mg

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10088

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10082

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 11yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Washington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hagerstown
   d. STREET ADDRESS: 34 High Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2103-2

3. NAME OF DECEASED (Type or print): First: Edgar — Middle: Lawrence — Last: Showe

4. DATE OF DEATH: Month: September — Day: 4 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 8, 1908

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical Work

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Showe

14. MOTHER'S MAIDEN NAME: Bertha Switzer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: 214-09-4952

17. INFORMANT — Address: Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to occlusion of larynx, trachea and — INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO bronchi with food.

921.7

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): C.B.S. associated with meningoencepholitic syphilis with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Aspirated food

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year: 9-4-61 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): S.S.H.

20f. (City or town) Sykesville (County) Carroll (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: James T Marsh M.D.

EXAMINER'S NAME (Type): James T. Marsh, M.D.

DATE SIGNED: 9-4-61

Address (Street, city, town, or county): Westminster, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/7/1961

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or country) (State): Hagerstown, Maryland

23. FUNERAL DIRECTOR: Suter - Rouzer Funeral Home — ADDRESS: Hagerstown, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 6 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10089

CERTIFICATE OF DEATH

Reg. Dist. No. 10083

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Mt Airy
c. LENGTH OF STAY IN 1b: 50yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Runkles Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Mt. Airy
d. STREET ADDRESS: 1 —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hannah Elizabeth Middle: Simms Last:

4. DATE OF DEATH: Month: September Day: 28 Year: 1961

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOV. 15, 1895
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Isaac Milton Waters
14. MOTHER'S MAIDEN NAME: Laura Jane Myers.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —

INFORMANT: Mrs. Rachel Ann Jones, Address: Mt. Airy (Home Address Baltimore)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive & Arteriosclerotic Cardiovascular Disease
DUE TO
443 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 9 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August, 1961, to Sept, 1961, that I last saw the deceased alive on Sept. 19, 1961, and that death occurred at 805 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W.B. Culwell M.D. ADDRESS (Street, city or town, state): Mt Airy, Md DATE SIGNED: Sept 28, '61

PHYSICIAN'S NAME (Type): W.B. Culwell

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-30-1961
22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery
22d. LOCATION (City, town, or county) (State): Carroll Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz ADDRESS: Winfield, Maryland
24a. REC'D BY REGISTRAR DATE: SEP 29 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10090

CERTIFICATE OF DEATH

10084

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: 36 yrs. 8 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hutton
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ ?

M

515

I

3. NAME OF DECEASED (Type or print): First: Frances — Middle: Ida — Last: Sisler

4. DATE OF DEATH: Month: 9 — Day: 6 — Year: 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: unknown

9. AGE (In years last birthday): 72? yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Springfield Hospital records — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cardiac insufficiency
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic Reaction, Catatonic Type in a Mental Defective.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 1/6 1925 to 9/6 1961, that ☒ (we) last saw the deceased alive on 9/6 1961, and that death occurred at 6 A.M. from the causes and on the date stated above.

22a. SIGNATURE: N. Naci N. Buyukunsal M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 9/6/61

22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: September 11 1961

23c. NAME OF CEMETERY OR CREMATORY: N.G. Mt. Carmel Cemetery

23d. LOCATION (City, town, or county): Baltimore, Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Frank A. Sewell

ADDRESS: Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: SEP 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10091

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10085

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 7 yrs. 10 mos. 18 dys

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1305 Linwood Avenue
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: Clara — Last: Skalski

4. DATE OF DEATH: Month: September — Day: 21 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: February 23, 1908

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Skalski

14. MOTHER'S MAIDEN NAME: Theresa Michalak Skalski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT: Springfield Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Suffication due to aspiration of food — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with convulsive disorder with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ **CAUSE OF DEATH.**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Aspirated food during epileptic seizure

20c. TIME OF INJURY Hour a.m.: 11:45 a.m. — Month, Day, Year: 9-21-61, 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Springfield State Hosp.

20f. (City or town) (County) (State): Sykesville, Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T Marsh M.D.
EXAMINER'S NAME (Type): James T. Marsh, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 9-21-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/25/61

22c. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cemetery

22d. LOCATION (City, town, or country) (State): Baltimore Co. Md.

23. FUNERAL DIRECTOR ADDRESS: John M. Weber & Sons Inc, 401 S. Chester St.

24a. REC'D BY REGISTRAR DATE: SEP 22 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10092

Reg. Dist. No. 10086

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Finksburg, RD
c. LENGTH OF STAY IN 1b: 7lyrs
d. NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION: Sandymount Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Finksburg RD
d. STREET ADDRESS: Sandymount Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Albert — Lost: Slorp

4. DATE OF DEATH: Month: September — Day: 20 — Yeor: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 20, 1889

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of wark done during most of working life, even if retired): retired Railroad worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (Stote or foreign country): Carroll Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John L. Slorp

14. MOTHER'S MAIDEN NAME: Minerva Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ——
(If yes, give war or dates of service) ——

16. SOCIAL SECURITY NO. ——

INFORMANT: Sally A. Slorp — Address: same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): none

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Manth, Doy, Yeor: none 19

20d. INJURY OCCURRED While at work ☐ Nat while at wark ☐

20e. PLACE OF INJURY (Home, form, factary, street, affice bldg., etc.): none

20f. (City or town) (County) (Stote)

21. I certify that I attended the deceased from 8-28-40, 19—, to 9-20-61, 19—, that I last saw the deceased alive an 2-13-61, 19—, and that death accurred at 1:50P.M., fram the causes and an the date stated abave.

ACTUAL SIGNATURE: D. D. Caples M.D. — ADDRESS (Street, city or tawn, stote): 6 Hanover Rd. — DATE SIGNED: 9-21-61

PHYSICIAN'S NAME (Type): D. D. Caples, M. D. — Reisterstown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: Sept. 23, 1961
22c. NAME OF CEMETERY OR CREMATORY: Sandymount Cemetery
22d. LOCATION (City, tawn, ar caunty) (State): Finksburg RD Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J. E. Myers, Jr., Westminster, Md.

24a. REC'D BY REGISTRAR DATE: SEP 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Preston

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar ta burial, cremation, ar removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10093

CERTIFICATE OF DEATH

10087

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Last residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 11
d. STREET ADDRESS: 2918 Huntington Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 Y 0 1 2 4

3. NAME OF DECEASED (Type or print): First: Florence — Middle: Emma — Last: Beckford Stansbury

4. DATE OF DEATH: Month: September — Day: 11, — Year: 19 61

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	MARRIED ☒	December 4, 1885	75 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Peter Beckford	Emma Ritchey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT — Address
No	-	-	Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept. 2, 1961 to Sept. 11, 1961, that (I) (we) last saw the deceased alive on September 11 19 61, and that death occured at 9:45 AM from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 9/11/61
22c. PHYSICIAN'S NAME (Type): Agustin delCampo, M.D.
22d. ADDRESS: Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	Sept. 14, 1961	DRUID RIDGE	BALTO Co

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Paul E. Clemonts Jr. 3617 Chestnut Ave.
25a. REC'D BY REGISTRAR DATE: SEP 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10094

CERTIFICATE OF DEATH

Reg. Dist. No. 10088

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYMAR
c. LENGTH OF STAY IN 1b YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYMAR
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First CORA Middle LAVINA Last SUMMERS

4. DATE OF DEATH Month SEPT Day 24 Year 1961

5. SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH JULY 13-1891

9. AGE (In years last birthday) 70 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY OWN HOME

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JACOB HOFFMAN

14. MOTHER'S MAIDEN NAME ELIZABETH SMITH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219-01-2041

17. INFORMANT MRS HERMAN MOORE Address JOHNSVILLE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 6 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 24 1961 to Sept 24 1961, that I last saw the deceased alive on Sept 24 1961, and that death occurred at 6:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE J. H. Messler M.D. ADDRESS (Street, city or town, state) Union Bridge DATE SIGNED Sept 25 1961

PHYSICIAN'S NAME (Type) J. H. MESSLER. MD UNION BRIDGE MD

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF SEPT 27-1961

22c. NAME OF CEMETERY OR CREMATORY ROCKY HILL

22d. LOCATION (City, town, or county) WOODSBORO (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE D D Hartzler & Sons ADDRESS Union Bridge MD

24a. REC'D BY REGISTRAR DATE SEP 27 '61

24b. REGISTRAR'S SIGNATURE Dallas S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

(M)

(I)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10089

1. PLACE OF DEATH
a. COUNTY: Carroll Co. — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Finksburg RD
c. LENGTH OF STAY IN 1b: hours
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer Park Rd & Benson Rd (Liberty Dam)

2. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 13 Ward Ave. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MOSES Middle BURNELL Last TROXELL

4. DATE OF DEATH: Month SEPT. Day 17 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 6, 1913
9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Carroll Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Moses J. M. Troxell
14. MOTHER'S MAIDEN NAME: Cora May Yeiser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 218-10-4231
17. INFORMANT: Benj. F. Troxell — Address: 60 Wash. Rd. Westminster Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): DROWNING — INTERVAL BETWEEN ONSET AND DEATH

929.8

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Went under water - Didn't Come up
20c. TIME OF INJURY: Hour 11 a.m. p.m. — Month, Day, Year: 9-17 1961
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Liberty Dam
20f. (City or town): Finksburg (County): Carroll (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James T. Marsh, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): JAMES T. MARSH
Address (Street, city, town, or county):
DATE SIGNED: 9/18/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/20/61
22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
22d. LOCATION (City, town, or country): Silver Run (State): Carroll Co. Md.

23. FUNERAL DIRECTOR: J. E. Myers, Jr. — ADDRESS: Westminster Md.
24a. REC'D BY REGISTRAR: DATE SEP 21 '61
24b. REGISTRAR'S SIGNATURE: Clinton S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10096 — Reg. Dist. No. 10090

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 yr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sudbrook Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Owings Mills — 03X-2
d. STREET ADDRESS: 5 Mason Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: — Last: VANDERBOSCH

4. DATE OF DEATH: Month: Sept — Day: 28 — Year: 19 61

5. SEX: male — 6. COLOR OR RACE: white — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 2-23-1879 — 9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Buffalo N Y — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Vanderbosch — 14. MOTHER'S MAIDEN NAME: Kunegunda Hartman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes Spanish Amn — 16. SOCIAL SECURITY NO.: — 17. INFORMANT: Frank J. Vanderbosch — Address: Owings Mills

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial pneumonia, Cardiac failure, — INTERVAL BETWEEN ONSET AND DEATH: 3-2-60
DUE TO
(b): Uremia, Carcinoma of prostate, — 9-28-61
DUE TO
(c):

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-2, 1960, to 9-28, 1961, that I last saw the deceased alive on 28 Sept, 1961, and that death occurred at 12 noon, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard E Hall M.D. — ADDRESS (Street, city or town, state): Sykesville, Md — DATE SIGNED: 28 Sept 61

PHYSICIAN'S NAME (Type): HOWARD E. HALL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10-2-61 — 22c. NAME OF CEMETERY OR CREMATORY: Calvary — 22d. LOCATION (City, town, or county) (State): Long Island City N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: Frank R. Powell — ADDRESS: Pikesville Md

24a. REC'D BY REGISTRAR — DATE: OCT 3 '61 — 24b. REGISTRAR'S SIGNATURE: Andrew S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10097

CERTIFICATE OF DEATH

10091

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dist
c. LENGTH OF STAY IN 1b): 10 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Dist
d. STREET ADDRESS: Klee Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JULIA — Middle ANN — Last WOODWARD

4. DATE OF DEATH: Month Sept. — Day 1 — Year 1961

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Aug. 29, 1906 — 9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: Home — 11. BIRTHPLACE (State or foreign country): Baltimore, Md. — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Nelson — 14. MOTHER'S MAIDEN NAME: Ella Louise Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): — — 16. SOCIAL SECURITY NO.: 214-16-3799 — 17. INFORMANT: Mr Clarence D. Woodward — Address: above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Bronchial pneumonia, Carcinoma	
153.8	DUE TO (b) Colon (Colostomy) Liver Metastasis	1960 To 1961
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (c) Anemia, Cardiac failure	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1960, 19__, to 1 Sept, 1961, that (I) (we) last saw the deceased alive on 1 Sept 1961, and that death occurred at 8:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Howard E. Hall M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2 Sept 61

22c. PHYSICIAN'S NAME (Type): HOWARD E. HALL — 22d. ADDRESS: Sykesville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 9-5-61 — 23c. NAME OF CEMETERY OR CREMATORY: Bethesda — 23d. LOCATION (City, town, or county) (State): Dist. Carroll Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Luther H. Haight — ADDRESS: Sykesville, Md — 25a. REC'D BY REGISTRAR — DATE SEP 5 '61 — 25b. REGISTRAR'S SIGNATURE: Irving S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10098

CERTIFICATE OF DEATH

10092

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 mo. 11 dys.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 26 Wall Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Anne		Yearley	September	13	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		February 9, 1879	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Secretary	Unknown	Iowa	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Solomon Yearley	Jane Samuels

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	-	213-16-9097	Springfield Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): C.B.S. associated with cerebral arteriosclerosis without qualifying phrase

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-2-, 1961 to 9-13-, 1961, that (I) (we) last saw the deceased alive on 9-13- 19 61, and that death occured at 2:45 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 9-13-61
22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.
22d. ADDRESS: Springfield State Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	9/16/61	St. Mary's Cemetery	Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey	Bethesda, Maryland	SEP 18 '61	Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10099 10093

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Manchester
c. LENGTH OF STAY IN 1b 44
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institutian: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Westminister RFD 3
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Lillie Middle Mabel Last Yingling
4. DATE OF DEATH Sept Day 7 Year 1961
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Dec 1-1880
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Littlestown, Pa
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Tobias Wm. Brown
14. MOTHER'S MAIDEN NAME Eleanor Crouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Address Mr. Milton Yingling Westminister 3, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Thrombosis	1 Month
DUE TO (b)	Arteriosclerotic Cardio Vascular Disease	10 yrs
DUE TO (c)	Hypertension	10 yrs

443X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1948 19 to Sept 7 1961, that (I) (we) last saw the deceased olive on Sept 7 1961, and that death occurred at 3:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE W H Foard M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) W. H Foard M.D.
22d. ADDRESS Manchester, Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9-16-61
23c. NAME OF CEMETERY OR CREMATORY Lutheran Cem - Manchester
23d. LOCATION (City, town, or county) (State) Carroll Co Md

24. FUNERAL DIRECTOR'S SIGNATURE Tipton - Elsie - ADDRESS Hampstead Md
25a. REC'D BY REGISTRAR DATE SEP 11 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59